1-1-2008

Psychologists' cognitive and emotional responses to working with borderline personality disorder clients

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Abstract

Borderline Personality Disorder (BPD) is commonly recognised throughout theoretical and clinical accounts as one of the most challenging mental health disorders to treat however; there has been limited empirical investigation into characteristic psychologists reactions evoked by this diagnostic group. The aim of this study was to investigate cognitive and emotional responses of psychologists treating BPD. Method: Psychologists currently working with BPD clients gave informed consent to be interviewed regarding their responses to this client group. In addition, the Impact Message Inventory (IMI-C) and the Psychotherapy Relationship Questionnaire (PRQ) were completed. Transcripts from a semi-structured interview of psychologist's countertransference experiences were coded and scored to reflect core ideas and responses that were consistent across cases, whilst allowing for individual variation. Results: Major themes that emerged included significant psychologist anxiety and worry both before and after sessions, and confusion and frustration within the session in relation to implementing specific therapeutic tasks and skills. Self-report measures supported the transactional patterns found within the client-therapist dyad. The results from this study increase the current knowledge of common themes, origins and manifestations of countertransference reactions in the treatment of BPD, aiding psychologists to incorporate this clinically important information into the treatment process.

Keywords

Psychologists, cognitive, emotional, responses, working, borderline, personality, disorder, clients

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

Publication Details

Bourke, M. E. & Grenyer, B. F. S. . (2008). Psychologists" cognitive and emotional responses to working with borderline personality disorder clients. In N. Voudouris & V. Mrowinski (Eds.), Proceedings of the 43rd Annual Australian Psychological Society Conference (pp. 46-50). Melbourne: Australian Psychological Society.

Psychologists' Cognitive and Emotional Responses to Working with Borderline Personality Disorder Clients

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Abstract

Borderline Personality Disorder (BPD) is commonly recognised throughout theoretical and clinical accounts as one of the most challenging mental health disorders to treat however; there has been limited empirical investigation into characteristic psychologist's reactions evoked by this diagnostic group. The aim of this study was to investigate cognitive and emotional responses of psychologists treating BPD. Psychologists currently working with BPD clients gave informed consent to be interviewed regarding their responses to this client group. In addition, the Impact Message Inventory (IMI-C) and the Psychotherapy Relationship Questionnaire (PRQ) were completed. Transcripts from a semi-structured interview of psychologist's countertransference experiences were coded and scored to reflect core ideas and responses that were consistent across cases, whilst allowing for individual variation.: Major themes that emerged included significant psychologist anxiety and worry both before and after sessions, and confusion and frustration within the session in relation to implementing specific therapeutic tasks and skills. Self-report measures supported the transactional patterns found within the client-therapist dyad. The results from this study increase the current knowledge of common themes, origins and manifestations of countertransference reactions in the treatment of BPD, aiding psychologists to incorporate this clinically important information into the treatment process.

Beck, Freeman, Davis et al. using the Cognitive Behavioural Model refer to personality disordered patients as having "idiosyncratic or repetitious reactions" that challenge the therapist in establishing and maintaining a therapeutic alliance (2003, p. 76). This phenomenon has generated considerable theoretical and clinical support (McWilliams, 1994) however, a comprehensive review of countertransference related literature by Rosenberger and Hayes (2002), identifies few studies that have focused on therapist reactions to specific client populations.

One such study used clinical vignettes to illicit reactions from 336 clinical psychology students (Brody & Farber, 1996). A vignette of a depressed client elicited feelings of nurturing, compassion and empathy, where as, the schizophrenia vignette was associated with reactions of anxiety and hopelessness. In contrast, the borderline personality disorder stimulus induced negative reactions of irritation, frustration and anger. Likewise, McIntyre and Schwartz (1998) reported that psychologists rated differential reactions towards audio taped client interviews. Psychologists had significantly higher reactions of hostility and feelings of being dominated towards borderline client stimulus and submissive and friendly responses towards the depressed client stimulus. While these studies support the notion of specific client evoked therapist reactions, the use of analogue designs may not accurately represent the dynamics of real-world client-therapist relations. A recent study using the Feeling Word Checklist-58 in a naturalistic paradigm reported that therapists expressed feelings of helpfulness towards borderline clients. In contrast, antisocial personality disordered clients influenced feelings of being overwhelmed, on guard and distant (Thylstrup & Hesse, 2008).

Previous studies using a variety of instruments indicate that therapist differential reactions to client diagnoses is a robust phenomena however, the divergent reports in the specific nature of therapist reactions indicate that further empirical investigation is warranted. Limitations of previous studies therefore include (a) reliance on analogue designs, (b) use of simple affect checklists, (c) students rather than working clinicians as participants, (d) use of instruments without established psychometric properties and, (e) limited generalisbility to clinical settings.

To our knowledge this is the first study to investigate clinician's central relationship patterns as measured by the Core Conflictual Relationship Theme method (CCRT). The CCRT codes relationship themes from a target's narrative into three components: what the target wanted from the other (W), how the other responded (RO), and how the target reacted (RS) (Crits-Christoph & Luborsky, 1990). While it is expected that the wish component of the psychologist's narrative would be

consistent across diagnostic groups, client response (RO) and the psychologist's response (RS), were hypothesised to be more negative (lower valence score) in relation to borderline clients compared to depressed clients. Similarly, transference dimensions as measured by the Psychotherapy Relationship Questionnaire (PRQ) were expected to differ as a function of client diagnosis. Consistent with McIntyre and Schwartz (1998), psychologists were predicted to feel dominated by and hostile towards borderline clients compared to depressed clients.

This study aimed to identify client interpersonal and psychologist intrapersonal responses that discriminate between borderline and depressed diagnostic groups. As previously highlighted by Singer and Luborsky (1977), the task of operationalising interpersonal interactions without removing the complexity of the dynamics is a challenge for quantitative research. With this in mind, the following study had several advantages over previous research: (a) increased ecological validity with reactions towards therapist's actual caseload clients, (b) use of experienced working psychologists, (c) use of structured questionnaires and psychologists' narratives; reflecting the complexities of the internal world of the psychologist.

Method

Participants

Eleven experienced clinical psychologists with either a masters or clinical doctorate degree were recruited.

Inclusion Criterion Psychologists were required to have a level of clinical experience of a minimum of 12 months treating Borderline Personality Disorder (BPD) and Major Depressive Disorder (MDD). To ensure recency of experience and accurate recall, clients included were required to either be currently in therapy or have had therapy terminated less than 12 months prior. The goal was to provide a representative sample of client variables by minimising selection bias associated with the recall of particular salient clients.

Client Selection and Diagnosis Psychologist's selected four clients as representative of their caseload that met the recency of treatment inclusion criteria, as well as the diagnostic criteria for BPD or major depression; providing a total dataset of 44 clients. All clients selected were clients of the health service, under care of the treating psychologist. Diagnoses were generally confirmed through a Diagnostic and Statistical Manual–fourth edition (DSM-IV; APA, 1994) structured interview following the MH-OAT (New South Wales Mental Health Outcomes Assessment) manualised assessment process. Independent verification of diagnoses by the researchers was not performed.

Measures

Client demographics and diagnoses were confirmed by participating psychologists in advance of the research interview (usually through a clinical chart review). Psychologists also provided their theoretical orientation, years of clinical practice, and clinical qualifications.

The Core Conflictual Relationship Theme Method (CCRT-LU; Albani et al., 2002) was designed to identify recurring relationship themes using the 119 published subcategories. Reliabilities for high and middle-level categories have been established with fair to good interrater agreement (kappa range 0.66 – 0.56; Albani et al., 2002); validity is shown through the relationship between treatment progress and CCRT modification in a client population (Crits-Christoph & Luborsky, 1990).

The Impact Message Inventory-Circumplex (IMI-C; Keisler & Schmidt, 2006) is a 56 item scale designed to measure covert emotional reactions depicted by eight scale scores.

The Psychotherapy Relationship Questionnaire (PRQ; Western, 2000) is a clinician-report questionnaire designed to measure a wide range of behavioural patterns consistently expressed by the client towards the therapist. Ninety items load on 5 factors that range in alpha coefficients from 0.94 to 0.84 (Badley, Heim & Western, 2005).

The Global Assessment of Functioning (GAF) rated by the psychologist at initial interview and follow-up, measured overall client mental health functioning.

Procedure

Each psychologist discussed their experiences in relation to two borderline clients and two depressed clients. Psychologists who agreed to participate were provided with client and psychologist demographic questionnaires to complete in their place of work prior to being interviewed, enabling them to do a chart audit to derive accurate client characteristics and diagnoses. Psychologists were audio taped for five minutes discussing a client with a primary diagnosis of depression, followed by the completion of the IMI-C and PRQ relating to that client. This was repeated for the next depressed client and two subsequent borderline clients. The recorded narratives were transcribed from which the psychologists' CCRT components were identified and scored.

Relationship Anecdotes Paradigm (RAP) The RAP is a semi-structured face-to-face interview procedure (Grenyer, 2002). Participants were asked to elaborate freely on (a) their wish or outcome goal, (b) how the client responded to them and, (c) the emotional and cognitive reactions they experienced.

Results

Sample Characteristics

Psychologists reported theoretical orientations including Cognitive Behavioural Therapy, Psychodynamic Psychotherapy, Interpersonal Psychotherapy, Transference Focused Therapy, and Acceptance and Commitment Therapy. Psychologist's average age was 34.5 years (SD = 7.68), with the numbers of years practicing ranging from 2 to 14 years (M = 6.70, SD = 3.01). Borderline and depressed clients included were predominately female, being 85% and 65% respectively. Table 1 provides a summary of client demographics and treatment variables compared using a factorial between groups analysis of variance (ANOVA); significant group differences were found in age, initial GAF, and follow-up GAF.

Table 1: Client Demographic and Treatment Variable Means (Standard Deviations) for Borderline Personality Disorder (BPD) and Major Depression (MDD).

Variable	BPD n = 22	MDD n = 22	p
Age	32.60 (9.36)	44.65 (15.36)	.005
Treatment duration (mths)	13.50 (10.07)	9.96 (13.85)	.326
Initial GAF	41.45 (10.42)	48.70 (9.77)	.029
Follow-up GAF	53.80 (11.36)	66.00 (9.40)	.001

Item Analysis

PRQ items reported by the psychologist to be most representative of the way the client approached therapy and responded to them differed between diagnostic groups, with higher scores for borderline clients compared to depressed clients. Table 2 presents 10 items that reflect psychologists dichotomous responses of "*very true*" for borderline clients and "*not true at all*" for depressed clients. In turn, psychologist's responses to the Impact Message Inventory indicated different emotional engagements when interacting with borderline clients compared to depressed clients. Table 3 depicts four high scoring items that describe psychologist's reactions towards each client group.

Table 2: Ten Most Frequent Psychotherapy Relationship Questionnaire (PRQ) Items

PRQ Items
34 Needs excessive admiration from the therapist
77 Repeatedly tests and fails to respect therapeutic boundaries
58 Behaves in ways that seem entitled
67 Is manipulative
24 Worries that the therapist doesn't like him/her
52 Is afraid of being abandoned by the therapist
36 Vacillates between idealising and devaluing the therapist
7 Is competitive with the therapist
28 Is provocative; tends to set up situations in which the therapist feels angry, attacked, or provoked
74 Is prickly; makes the therapist feel like s/he is "walking on eggshells"

Note: Responses "very true" for borderline clients and "not true at all" for depressed clients (N = 44).

Table 3: Top Four High Scoring IMI-C Items for Borderline Clients and Depressed Clients.

IMI-C Items
Item responses to borderline clients (n = 22)
1. Appears that s/he wants me to put him/her on a pedestal
2. Appears that s/he thinks s/he can't do anything for themselves
3. Feel bossed around
4. Appears that s/he wants to be the center of attention
Item responses to depressed clients (n = 22)
1. I can ask him/her to carry their share of the load
2. Appears that s/he trusts me
3. Feel appreciated by him/her
4. Feel complimented by him/her

IMI-C = Impact message Inventory-Circumplex

Differential Emotional Responses: Discriminate Function Analysis

A test of dimensionality for IMI-C octant scores and five PRQ factor scores were significant, with a large canonical correlation of 0.87, p = .000, between response variables. Standardised canonical coefficients indicate that PRQ factors were weighted by narcissism (-1.64), compliant/anxious (-0.33) and hostility (0.28), while avoidant/dismissive and working alliance factors did not significantly contribute to the model. IMI-C octant scale scores contributed significantly on dominant (1.42) and friendly-dominant (-1.00) dimensions (dimensions of friendly, friendly-

submissive, submissive, hostile-submissive, hostile, and hostile-dominant did not significantly contribute to the model). Therefore, three client interpersonal interaction variables (narcissism, compliant/anxious and hostility) and two psychologist variables of covert emotional reactions (dominant and friendly-dominant) accurately classified 95.50% of depressed clients and 81.80% of borderline clients.

Inter-rater Reliability

Two judges rated approximately 8% of the total data set on the Core Conflictual Relationship Theme. Agreement was moderate with kappa coefficients obtained: .51, $p < .001$ for the first category (harmonious/disharmonious); .47, $p < .001$ at the cluster level (e.g., Cluster C.); .43, $p < .000$ at the midlevel category (e.g., C4.). CCRT valance ratings correlated between raters $r = .73$, $p < .000$.

CCRT Valance

Psychologists reported a consistent wish to develop a therapeutic alliance, and to facilitate change in the client regardless of the patient diagnosis. One-way ANOVAs indicated that psychologists perceived BPD clients responses to them, as coded from their verbal descriptions, to be more negative than MDD clients, $F(1,18) = 16.45$, $p < .001$. In addition psychologists had significantly greater negative intrapersonal responses in relation to borderline clients than MDD clients, $F(1,18) = 9.26$, $p < .007$, as presented graphically in Figure 1.

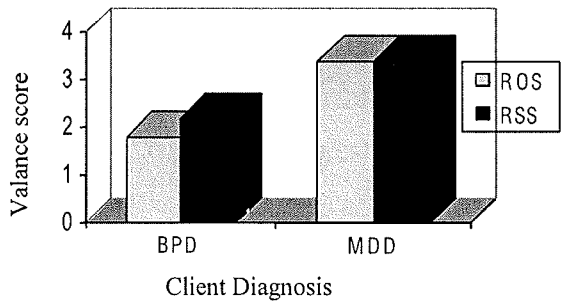

Figure 1: Average valence scores on the CCRT components; client response to psychologist (ROS) and response of psychologist to self (RSS) for borderline clients ($n = 10$) and depressed clients ($n = 10$); 1 = *very negative*, 2 = *negative*, 3 = *positive*, 4 = *very positive* (Grenyer & Luborsky, 2002).

Discussion

This study aimed to identify client interpersonal and therapist intrapersonal responses that discriminate between borderline and depressed diagnostic groups. Results indicate that borderline clients commenced therapy with lower GAF scores, which remained at a significantly lower lever compared to depressed clients. This suggests that borderline clients show consistently greater psychopathology making them therapeutically more challenging clients to treat. While psychologists were motivated by similar therapeutic goals to help and facilitate change regardless of diagnosis, they encountered greater resistant and hostile responses from borderline clients. This in turn evoked self-doubt, frustration and anxiety before, during and after therapeutic engagement. These themes were reflected in both psychologists' self-report and observer rated measures.

Consistent with Bradley, Heim and Western (2005), the highest loadings of narcissism and hostile dimensions of client interaction patterns, as measured by the PRQ, discriminate group membership. Higher scores for borderline clients suggest that they more frequently placed unrealistic demands on the psychologist in conjunction with being dismissive and angry. Furthermore borderline clients were reported to respond anxiously and compliantly, indicating a tendency towards fear of rejection and criticism. Thus, borderline clients were perceived to display greater inconsistencies in their interpersonal interactions.

While it is acknowledged that all psychologists display their own unique intrapersonal responses, an aggregation of these responses toward borderline clients load on the dimension of feeling dominated, as measured by the IMI-C. Psychologists were more likely to feel that they were controlled by the borderline client, and worried about being manipulated; being reactions congruent with non-cooperative and resistant interpersonal interactions. The current study provides partial support for the McIntyre and Schwartz (1998) results that borderline clients evoked feelings of being dominated, however this study did not find significant differences in hostile responses toward either client group. Moreover, psychologists also reported experiencing pulls of friendly affiliation, indicating a push-pull dynamic in contrast to depressed clients who seem more consistent in their interpersonal interactions.

A limitation of this study is that the client sample was derived from a smaller sample of psychologists; therefore data may be hierarchically structured with response variation nested within the psychologist sample. Additionally there are numerous extraneous variables in each client-therapist dyad. This study assumes that there are consistent response patterns within diagnostic groups however the broad spectrum of diagnostic presentations in borderline clients as indicated by variance in initial GAF scores ($SD = 10.42$) compared to depressed clients ($SD = 9.77$) would indicate that there are considerable variations in initial presentation. The current design would be

improved with additional clinical data to further account for within group variation. A common criticism levelled at all empirical investigations that rely on self-report data is the possibility that responses are biased, motivated by social conformity. While this cannot be ruled out, it is difficult to conceive of a response pattern that could account for these results. Additionally, reliable observer ratings corresponded with self-reports suggesting that these measures are valid.

In summary, our results are consistent with clinical and theoretical literature regarding interpersonal interaction patterns of depressed and borderline client populations. Moreover, results provide empirical support for the theoretical position that psychologists have differential intrapersonal reactions based on client type. There may be considerable worth in future investigations into the application and integration of this important information into the therapeutic process. A greater awareness of the contradictory bombardment of affects expressed by borderline personality disordered clients may serve to normalise these experiences, having direct utility in the therapeutic environment or indirect application in self-care and supervision. Psychologist's insights into common themes and manifestations of their own emotional reactions may be personally beneficial as well as enhancing the client's therapeutic experience.

Acknowledgements

The clinical psychologist participants, Karin Sandquist for data entry, Kate Lewis for rating part of the data, Marie Johnson and Naomi Jama for transcription, a grant from the Commonwealth Dept Human Services and Health (to B. Grenyer) and the Bourke Biopsychosocial Foundation.

References

Albani, C., Pokorny, D., Blaser, G., Gruninger, S., Konig, S., Marschke, F., Geissler, I., Koerner, A., Geyer, M. & Kachele, H. (2002). Reformulation of the Core Conflictual Relationship Theme (CCRT) Categories: The CCRT-LU Category System. *Psychotherapy Research, 12*, 319-338.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders, 4th edition.* Washington, DC: American Psychiatric Association.

Bradley, R., Heim, A. K., & Westen, D. (2005). Transference patterns in the psychotherapy of personality disorders: Empirical investigation. *British Journal of Psychiatry, 186,* 342-349.

Beck, A. T., Freeman, A., Davis, D.D., Pretzer, J., Davis, D. D., Fleming, B., Ottaviani, R., Beck, J., Simon, K. M., Padesky, C., Meyer, J., & Trexler, L. (2003). *Cognitive therapy of personality disorders.* New York: Guilford Press.

Brody, E. M. & Farber, B. A. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy, 33*, 372-380.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy, in L. Luborsky and P. Crits-Christoph, *Understanding Transference.* New York: Basic Books.

Grenyer, B. F. S. (2002). *Mastering relationship conflicts: Discoveries in theory, research and practice.* Washington DC: American Psychological Association.

Grenyer, B. F. S. & Luborsky, L. (2002). Positive and negative CCRTs, In L. Luborsky and P. Crits-Christoph, *Understanding Transference* (2nd ed. Eds.) New York: Basic Books.

Kiesler, D. J., & Schmidt, J. A. (2006). *The Impact Message Inventory-Circumplex (IMI-C) manual.* Redwood City, CA: Mind Garden.

McIntyre, S. M., & Schwartz, R. C. (1998). Therapists' differential countertransference reactions towards clients with major depression or borderline personality disorder. *Journal of Clinical Psychology, 54*, 923-931.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York: Guildford Press.

NSW Department of Health (2001). *Your guide to MH-OAT: Clinicians' reference guide to NSW Mental Health Outcomes and Assessment Tools.* Sydney, NSW: NSW Department of Health.

Rosenberger, E. W., & Hayes, J. A. (2002). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling & Development, 80*, 264-270.

Singer, B. A., & Luborsky, L. (1977). Countertransference; The status of clinical versus qualitative research . In A. Gurman & A. Razin (Eds.), *Effective psychotherapy: Handbook of research.* New York: Pergamon.

Thylstrup, B., & Hesse, M. (2008). Substance abusers' personality disorder and staff members' emotional reactions. *BMC Psychiatry 8*, 21-26.

Westen, D. (2000). *Psychotherapy Relationship Questionnaire (PRQ) Manual.* Available at http://www.psychsystems.Net/lab